TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Corpus Christi Prosthetics, Inc.

Respondent Name
Corpus Christi ISD

MFDR Tracking Number
M4-15-3236-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting additional payment due to the initial payment does not even cover our cost for the part. At this time we are appealing what is owed and customary of 80% of billed charges."

Amount in Dispute: $216.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 19, 2015. The insurance carrier did not submit a response for consideration in this review. Per the 28 Texas Administrative Code §133.307(d)(1), "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2014	L7510	$216.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets for general provisions related to reimbursement policies and guidelines.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Did the requestor support additional payment is due?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 309 – "The charge for this procedure exceeds the fee schedule allowance." Review of the DMEPOS fee schedule and Texas Medicaid fee schedule finds no value for the submitted code in dispute. 28 Texas Administrative Code §134.203(d) states,

> The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
>
> (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
>
> (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section

28 Texas Administrative Code 134.203 (f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

Texas Administrative Code 134.1 (e)(f) state,

> (e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
>
> (1) the Division's fee guidelines;
>
> (2) a negotiated contract; or
>
> (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.
>
> (f) Fair and reasonable reimbursement shall:
>
> (1) be consistent with the criteria of Labor Code §413.011;
>
> (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
>
> (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

2. The requestor states, "At this time we are appealing what is owed and customary of 80% billed charges." 28 Texas Administrative Code §133.307 (2) states,

> The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include:

(O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;

Review of the submitted documentation finds;

a. Insufficient documentation to support how requested payment relates to fees charge for similar treatment.

b. Insufficient documentation that supports that similar procedures provided in similar circumstances receive similar reimbursement; and

c. Insufficient documentation that supports requested fee is based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

The requirements of Rule 134.1(f) were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.